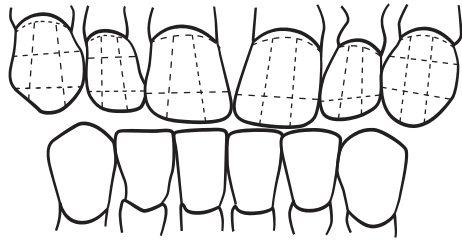


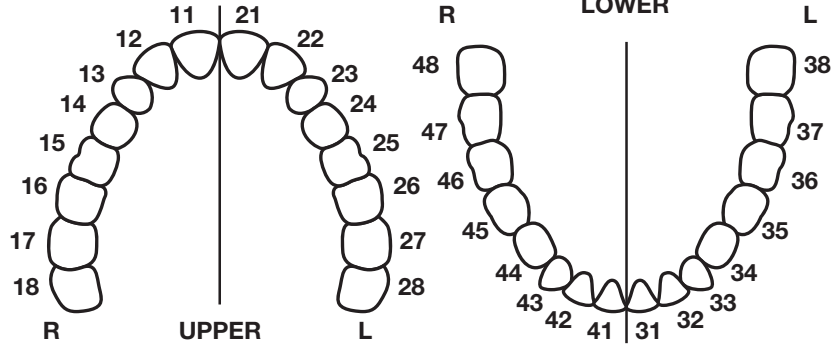
IT IS VERY IMPORTANT THAT CLIENTS FILL IN ALL SHADED AREAS IN THE SECTION BELOW.

Lab No. _____
Date Required. _____

SPECIAL MARKINGS



Please illustrate your design below



SURGEON AND ADDRESS

TELEPHONE NUMBER

PATIENT NAME

PATIENT NAME

SHADE

Female
Male
Age

CLASSIFICATION

Standard
Private
Signature

CASE INSTRUCTIONS

Teeth to be Extracted _____

TRAY	U	
DELIVERY DATE	L	
BITE		
DELIVERY DATE		
TRY-IN	Mould	Shade
DELIVERY DATE		
RE-TRY		
DELIVERY DATE		
FINISH		
DELIVERY DATE		